

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY QUEEN ANNE'S				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL QUEENSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 1712				
3. NAME OF DECEASED (Type or print) First MARION Middle DEADY Last ANDRUS					4. DATE OF DEATH Month SEPTEMBER Day 4 Year 1966				
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1905		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Oays IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIFE				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Pawling Dutchess Co., N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maybury Burton DeadY					14. MOTHER'S MAIDEN NAME Elizabeth Ferriss				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 218-48-5591		17. INFORMANT husband Address LEON A. ANDRUS, QUEENSTOWN, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of the stomach OUE TO (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Uncertain	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-2 , 19 66 , to 9-4 , 19 66 , that (I) (we) last saw the deceased alive on 9-3 , 19 66 , and that death occurred at 7 A M, from the causes and on the date stated above.									
22a. SIGNATURE Robert W. Trever								22b. DATE SIGNED 9/4/66	
22c. PHYSICIAN'S NAME (Type) Robert W. TREVER								22d. ADDRESS Easton, Maryland	
23a. PREVIOUS CREMATION <input checked="" type="checkbox"/> (Specify) CREMATION			23b. DATE THEREOF Sept. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		23d. LOCATION (City, town or county) (State) Wilmington, Delaware		
24. FUNERAL DIRECTOR James H. Burton Jr., Baltimore, Md.						25a. REC'D BY REGISTRAR SEP 7 1966		25b. REGISTRAR'S SIGNATURE John Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13256											
13249											
1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels c. LENGTH OF STAY IN b 2 wks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rio Vista Nursing Home						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels d. STREET ADDRESS Water St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LUCY PEARL BAYNARD						4. DATE OF DEATH Month September Day 29 Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 8, 1874		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Talbot County, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Dawson Caulk						14. MOTHER'S MAIDEN NAME Margaret Donaphin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-52-7856		17. INFORMANT Address Mrs. John Lewis, Marion, So. Carolina					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive-atherosclerotic DUE TO (a), stating the underlying cause last. (c) cerebrovas d. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic cardiac failure INTERVAL BETWEEN ONSET AND DEATH 48 hr.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1953 to 9-29-66 , that (I) (we) last saw the deceased alive on 9-29-66 , and that death occurred at 1:54 P.M. from the causes and on the date stated above.											
22. SIGNATURE Wm M Reeser Jr M.D. 22c. PHYSICIAN'S NAME (Type) Wm M Reeser Jr						22b. DATE SIGNED 9-30-66 22d. ADDRESS St Michaels md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery			23d. LOCATION (City, town or county) (State) St. Michaels, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Hampton Harrison ADDRESS St Michaels md						25a. REC'D BY REGISTRAR DATE OCT 5 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Talbot					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels				c. LENGTH OF STAY IN 1b 4 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels				d. STREET ADDRESS 20-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ETHEL MARIE BRAUER			First Middle Last			4. DATE OF DEATH September 20, 19 66			Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Dec 30, 1912		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank J. Hart						14. MOTHER'S MAIDEN NAME Elizabeth Goetz					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 139-34-0889		17. INFORMANT Address August Brauer, St. Michaels, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-21-66 Address (Street, city, town, or county) Patterson, New Jersey											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 24, 1966		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery				22d. LOCATION (City, town, or county) St. Michaels			
23. FUNERAL DIRECTOR L. Hamilton Harrison		24a. REC'D BY REGISTRAR SEP 26 1966		24b. REGISTRAR'S SIGNATURE J. Hamilton Harrison							

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>4 wks.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY Covington Butler</u>		4. DATE OF DEATH <u>9</u> <u>17</u> <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1888</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Queenstown, D.A. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Bryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>213-20-3760</u>	
17. INFORMANT <u>Wife</u> Address <u>Mrs. Ruth P. Butler, Centreville, Md. 21617</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-13</u> , 19 <u>66</u> to <u>9-17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-17</u> , 19 <u>66</u> , and that death occurred at <u>8:20</u> A.M. from causes on and the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u> M.D.		22b. DATE SIGNED <u>9-20-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney, M.D.</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept. 19, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Centreville, Maryland 21617</u>
24. FUNERAL DIRECTOR <u>James H. Butler Jr., Butler Bur. Centreville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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London, Maryland

Seaton L. Carney, R.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St. Michaels c. LENGTH OF STAY IN 1b 5 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rio Vista Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Emma C. Cooper First Middle Last					4. DATE OF DEATH 9/28/66 Month Day Year									
5. SEX FEMALE		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/1880		9. AGE (In years last birthday) 86 IF UNDER 1 YEAR: Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Reg. Nurse					11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md.			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Samuel F. Cooper					14. MOTHER'S MAIDEN NAME Anna Rasin									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes					16. SOCIAL SECURITY NO. WW 1 215 48 6331		17. INFORMANT Julia Matthews - P.O. Box Chestertown, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Myocardial Infarction</i> (c) <i>Generalized Cerebrovascular Vascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH 15 yr.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10-19, 1966 to 9-28, 1966, that (I) (we) last saw the deceased alive on 9-27, 1966, and that death occurred at 3:57 P.M. from the causes and on the date stated above.														
22a. SIGNATURE <i>R. Lane Wroth</i> 22c. PHYSICIAN'S NAME (Type) R. Lane Wroth					22b. DATE SIGNED 9-29-66 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 10/1/66		23c. NAME OF CEMETERY OR CREMATORY Chester Cem.		23d. LOCATION (City, town or county) (State) Chestertown, Md.					
24. FUNERAL DIRECTOR <i>W. Willis Wells</i> ADDRESS Chestertown, Md.					25a. REC'D BY REGISTRAR DATE OCT 4 1966					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13260											
1. PLACE OF DEATH a. COUNTY <u>Salhat</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNE'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> d. STREET ADDRESS <u>172</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Elizabeth</u> Last <u>PINDER</u>						4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 12, 1888</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE'S Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES FRANK PINDER</u>						14. MOTHER'S MAIDEN NAME <u>Molly PINDER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-10-0704-A</u>		17. INFORMANT <u>Miss BERTHA E. Dadds</u>		Address <u>Centreville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative bacteremia</u> DUE TO (b) <u>0534</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis. Arteriosclerotic ht. disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8-30-66</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>66</u> to <u>9-1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-31</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert W. Trever</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>						M.D. ADDRESS <u>Easton, Maryland</u>		22d. DATE <u>9/1/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Centreville, Maryland</u>		23e. REC'D BY REGISTRAR <u>21617</u>			
24. FUNERAL DIRECTOR <u>James H. Butler, Jr., Centreville, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13261					13254				
1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 3 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES, INC. EASTON					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton d. STREET ADDRESS 20 S. Harrison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna First K. Middle Earle Last			4. DATE OF DEATH Month 9 Day 12 Year 19 66						
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/1869	9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elias O. Dawson				14. MOTHER'S MAIDEN NAME Anna K. Groome					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 220-44-6709		17. INFORMANT Address Mrs. C. Loundes Johnson, Easton, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 609X DUE TO Chronic urinary infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured hip before 1966 July								INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 31, 1966 to 12 Sep, 1966 , that (I) (we) last saw the deceased alive on 31 Aug 1966 , and that death occurred at 7.15 PM from the causes and on the date stated above.									
22a. SIGNATURE Stephen P. Canye			22b. DATE SIGNED 9-12-66						
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/14/1966		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town or county) (State) Easton, Md.		
24. FUNERAL DIRECTOR Maurice E. Vennema, Sr.			ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR SEP 14 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE				b. COUNTY							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				b. ASCVD				c. Uremia				INTERVAL BETWEEN ONSET AND DEATH Hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 9-7, 1966 to 9-9, 1966, that (I) (we) last saw the deceased alive on 9-7, 1966 and that death occurred at 7 PM, from the causes and on the date stated above.															
22a. SIGNATURE				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							

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A.C.A.

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White matter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. Page 2 of 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

Item #2b,c, & d Film#G3381 9/28/66 mb																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
13253 Item 8 Film G381 9/28/66 mb																			
13256																			
1. PLACE OF DEATH a. COUNTY Talbot				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 17 yrs.				2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a. STATE Md.				b. COUNTY Talbot/ Q.A.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Home for Aged Women, Inc.) 108 N. Higgins				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton, Md. qq/ Queenstown 17-2				d. STREET ADDRESS 108 N. Higgins/							
3. NAME OF DECEASED (Type or print) Lavania May Ely				4. DATE OF DEATH Month 9/19/66 Day 19 Year 19				5. SEX F				6. COLOR OR RACE W							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4/26/66 1877				9. AGE (In years last birthday) 89 yrs.				IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Queen Anne, Md.				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William D. Wrightson				14. MOTHER'S MAIDEN NAME Martha A. Thursby				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. none							
17. INFORMANT records of Home for Aged Women of Easton				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) Diabetes				INTERVAL BETWEEN ONSET AND DEATH 2 days many yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from....., 19....., to..... 19 Sep, 19 66 , that (I) (we) last saw the deceased alive on..... 18 Sep, 19 66 , and that death occurred at..... 6 A. M, from the causes and on the date stated above.							
22a. SIGNATURE Stephen B. Carr M.D.				22b. ADDRESS 19 Sep 66				22c. PHYSICIAN'S NAME (Type) Stephen B. Carr				22d. DATE SIGNED 19 Sep 66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/21/66				23c. NAME OF CEMETERY OR CREMATORY Loudon Park				23d. LOCATION (City, town or county) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE The Jay D. Heverin Funeral Home, Easton, Md.				25a. REC'D BY REGISTRAR SEP 26 1966				25b. REGISTRAR'S SIGNATURE Charles Judge				25c. REGISTRAR'S SIGNATURE							

1925
Tribot

Lesson

Joe M. Higgins

Levanis Day 217

1/22/26

House wife

Joan Anne, 18

William A. Thayer

William D. Richardson

Records of Home for aged women of Boston

Baltimore, Md.

London Park

1925

The Jay D. Heverin Funeral Home, Boston, Mass.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in a vault within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON	c. LENGTH OF STAY IN 1b LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTON, Rt. 2		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle HENRY Last EMORY		4. DATE OF DEATH Month 9 Day 4 Year 1966	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 83 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John EMORY		14. MOTHER'S MAIDEN NAME MARGARET CLAYTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 419-14-4450	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
ACTUAL SIGNATURE Louis J. Welty EXAMINER'S NAME (Type) WELTY		22. DATE SIGNED 9-8-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-10-66	23c. NAME OF CEMETERY OR CREMATORY NEW CHAPEL CEM.	23d. LOCATION (City or Town) (County) (State) Talbot Md
24. FUNERAL DIRECTOR James B. Daskill		25a. REC'D BY REGISTRAR DATE SEP 14 1966	
ADDRESS EASTON, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form WM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13265

13258

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cordova Easton (rural) XXXXX</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cordova</i> 20-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
<i>James Otis Faulkner, Sr.</i>				<i>Sept. 9</i>		<i>1966</i>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>male</i>	<i>white</i>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>6/12/1932</i>	<i>34</i> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Truck driver</i>		<i>Morris E. Taylor Contractors, Inc.</i>		<i>Maryland</i>		<i>USA</i>	
13. FATHER'S NAME <i>Otis Faulkner</i>				14. MOTHER'S MAIDEN NAME <i>Anna Brooks</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
<i>no</i>		<i>213-26-7434</i>		<i>Mrs. James O. Faulkner, Cordova, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>15. W. head</i> <i>976X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <i>23</i> p.m. <i>9-9</i> 19 <i>66</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Woods</i>		20f. (City or town) (County) (State) <i>in Easton Tal Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
<i>Louis Melty</i>		<i>INELTY</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<i>9-9-66</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>9/13/1966</i>		<i>Woodlawn Memorial Park</i>		<i>Easton, Md.</i>	
23. FUNERAL DIRECTOR ADDRESS				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
<i>MURICE E. NEUNAM & SON, Easton, Md.</i>				DATE <i>SEP 15 1966</i> <i>J Charles Judge</i>			

MEDICAL CERTIFICATION

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MINISTRY OF DEFENCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #2b & c Film #G381 10/3/66 ps									
13256 CERTIFICATE OF DEATH 13259									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN lb <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton,</u>			20 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>222 Glenwood Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Alfred</u> Last <u>Gooby</u>					4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH Gooby</u>					14. MOTHER'S MAIDEN NAME <u>MARY Roberts</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>			16. SOCIAL SECURITY NO. <u>179-01-6228</u>		17. INFORMANT <u>HOSPITAL REC.</u> Address <u>EASTON, Md</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral apoplexy</u> DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Generalized atherosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia (months) Diabetes mellitus (years)</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 29, 1966</u> to <u>Sept 22, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 22, 1966</u> , and that death occurred at <u>3:45 PM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Dale R. Kollman</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 22, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dale R. Kollman, M.D.</u>					22d. ADDRESS <u>12 N. Hanson; Easton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B-27-66</u>		23b. DATE THEREOF <u>8-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards. Cem</u>			23d. LOCATION (City or Town) (County) (State) <u>Easton, Talbot, Md.</u>		
24. FUNERAL DIRECTOR <u>James S. Roswell, Easton, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
13260													
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>TALBOT</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>RURAL TRAPPE</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>						d. STREET ADDRESS <i>LITTLE MT. HOPE FARM</i>							
3. NAME OF DECEASED (Type or print) <i>Glen T. Hallowell</i>						4. DATE OF DEATH Month <i>9</i> Day <i>8</i> Year <i>1966</i>							
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 31, 1908</i>		9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>8</i> Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RESIDENT: AUTO SALES</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>AUTOMOTIVE SALES</i>		11. BIRTHPLACE (County & State, or foreign country) <i>DORCHESTER Co., MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Wesley Hallowell</i>						14. MOTHER'S MAIDEN NAME <i>Belle Stewart</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>214-30-8063</i>		17. INFORMANT <i>MRS. GLENN T. Hallowell</i> Address <i>LITTLE MT. HOPE FARM TRAPPE, MD.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive upper intestinal hemorrhage</i> 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Esophageal varices</i> DUE TO (c) <i>Cirrhosis of the liver</i>												INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>(?)</i> <i>(?)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10 June</i> , 19 <i>66</i> , to <i>8 Sept</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7 Sept</i> , 19 <i>66</i> , and that death occurred at <i>8:00</i> M, from the causes and on the date stated above.													
22a. SIGNATURE <i>Thurston Harrison</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8 Sept 66</i>					
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>						22d. ADDRESS <i>Easton Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>9-10-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL</i>		23d. LOCATION (City, town or county) (State) <i>EASTON - MD.</i>							
24. FUNERAL DIRECTOR <i>Charles Judge</i> ADDRESS <i>Easton, Md.</i>						25a. REC'D BY REGISTRAR <i>SEP 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

1951

UNITED STATES OF AMERICA

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EXHIBITION FIBER



UNITED STATES OF AMERICA
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>13268</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <i>Talbot</i> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Dr. Office's (Spencer Building)</i></p>						<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</p> <p>a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i></p> <p>d. STREET ADDRESS</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <i>James</i> Middle <i>Dobson</i> Last <i>Harrison, Jr.</i></p>						<p>4. DATE OF DEATH</p> <p>Month <i>9</i> Day <i>15</i> Year <i>1966</i></p>					
<p>5. SEX <i>male</i></p>		<p>6. COLOR OR RACE <i>white</i></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>6/14/1920</i></p>		<p>9. AGE (In years last birthday) <i>46</i> yrs.</p>		<p>IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i></p> <p>IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <i>Garage</i></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>USA</i></p>			
<p>13. FATHER'S NAME <i>James Dobson Harrison, Sr.</i></p>						<p>14. MOTHER'S MAIDEN NAME <i>Mary Mushaw</i></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>WWII</i></p>				<p>16. SOCIAL SECURITY NO. <i>220-01-8388</i></p>		<p>17. INFORMANT Address <i>Mrs. J. Dobson Harrison, Tilghman, Md.</i></p>					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i></p> <p>(b) <i>Coronary Artery Hardening</i></p> <p>(c) <i>Due to</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <i>9-15</i>, 19<i>66</i>, to <i>9-15</i>, 19<i>66</i>; that (I) (we) last saw the deceased alive on <i>9-15</i>, 19<i>66</i>, and that death occurred at <i>6:15</i> M, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <i>J. Paul Whaley</i></p>						<p>22b. DATE SIGNED</p>		<p>22c. PHYSICIAN'S NAME (Type) <i>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></i></p>			
<p>22d. ADDRESS</p>						<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>					
<p>23b. DATE THEREOF <i>9/18/1966</i></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i></p>		<p>23d. LOCATION (City, town or county) (State) <i>Tilghman, Md.</i></p>		<p>24. FUNERAL DIRECTOR ADDRESS <i>MURPHY E. NEUNAM & SON, Easton, Md.</i></p>		<p>25a. REC'D BY REGISTRAR <i>SEP 20 1966</i></p>		<p>25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i></p>	

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DEPARTMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13269

13262

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN lb <u>7 d.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARLTON</u> Middle <u>S</u> Last <u>HERSHEY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>65</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Hershey</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-54-5254</u>	
17. INFORMANT <u>Mrs. Charles Fortenbaugh, Oxford, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO (b) <u>2nd & Benck Hospital Prostate</u> DUE TO (c) <u>Supra Ectostomy</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John N. Robinson</u>		22b. DATE SIGNED <u>9/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John N. Robinson</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/29/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Landing Neck</u>	23d. LOCATION (City or Town) (County) (State) <u>Trappe, Md.</u>
24. FUNERAL DIRECTOR <u>Maurice E. Newnam & Son</u>		25. REC'D BY REGISTRAR <u>SEP 30 1966</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13231

CERTIFICATE OF DEATH

13231

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13270

13263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>7 DA.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTERVILLE 17-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY LOUISE ITALY</u> First Middle Last		4. DATE OF DEATH <u>9</u> Month <u>8</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 1, 1923</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR: Months <u>43</u> Days <u>43</u> IF UNDER 24 HRS. Hours <u>43</u> Min. <u>43</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William ITALY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE ITALY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-9694</u>	
17. INFORMANT <u>Hospital Records</u> Address <u>Easton Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO <u>Chronic nephritis (nephrosclerosis and diabetic nephropathy)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension and diabetes mellitus</u> (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure. Secondary anemia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>66</u> to <u>9/8</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carmackall Cem -</u>	23d. LOCATION (City or Town) (County) (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>James D. Abigail, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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Robert M. Trevett, D.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13271					13264				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		TALBOT MARYLAND			a. STATE		MARYLAND QUEEN ANNE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		EASTON			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		PRICE 17-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Memorial Hospital									
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH					
First Middle Last				Month Day Year					
Charles Edward JARRELL				Sept 26 19 66					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 12-1910 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CARPENTER				xx		MARYLAND		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
HARRY JARRELL					ANNIE TODD				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
					MRS. MYRTLE JARRELL - CHURCH HILL MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) DUE TO DUE TO DUE TO								INTERVAL BETWEEN ONSET AND DEATH Uncertain	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 17, 19 66 to Sept 26, 19 66 that (I) (we) last saw the deceased alive on Sept 26, 19 66, and that death occurred at 7:30 P.M. from causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
Robert W. Trever					9-26-66				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
ROBERT W. TREVER					Easton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		SEPT. 28		CHURCH HILL		CHURCH HILL MD.			
24. FUNERAL DIRECTOR				25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Edgar L. Lane				DATE SEP 27 1966		Charles Judge			

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INSTITUTE OF DESIGN

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THIS IS THE FIRST OF TWO PAGES OF THE
FORM. THE SECOND PAGE IS ATTACHED
TO THE FIRST PAGE. THE FORM IS
TO BE FILLED OUT BY THE
DESIGNER OF THE PROJECT.

THE FORM IS TO BE FILLED OUT BY THE
DESIGNER OF THE PROJECT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Denton</u>												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>					d. STREET ADDRESS <u>Box 204</u>												
3. NAME OF DECEASED (Type or print) <u>Mrs. Anna Wilhelmine Keating</u>					4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1966</u>												
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1899</u>		9. AGE (In years last birthday) <u>66</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>								
13. FATHER'S NAME <u>Henry Schlothauer</u>					14. MOTHER'S MAIDEN NAME <u>Minnie ?</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Helen Loukides</u> Address <u>(Same)</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma metastatic to lung</u> (b) <u>and liver, primary unknown</u> (c) <u>1992</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from <u>9-2</u> , 19 <u>66</u> , to <u>9-24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>66</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.																	
22a. SIGNATURE <u>Robert W. Trever</u>								22b. DATE SIGNED <u>9-24-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>					22d. ADDRESS <u>Easton, Md.</u>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>											
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto Md.</u>					25a. REC'D BY REGISTRAR <u>J. E. Boulares Greensboro, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>										

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u> d. STREET ADDRESS <u>Box 8 21665</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Virginia Kennard</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 6, 1899</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>9 24 1966</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Doudiken, Sr.</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Stewart R. Kennard</u> Address <u>same address</u> 14. MOTHER'S MAIDEN NAME <u>Shipley</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1750</u> DUE TO <u>Carcinoma of Ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Carcinoma of Ovary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yr.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1966</u> to <u>24 Sept 1966</u> , that (I) (we) saw the deceased alive on <u>24 Sept 1966</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above. 22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>9-25-66</u> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/28/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> 23d. LOCATION (City or Town) (County) (State) <u>Balto, Md.</u>		24. FUNERAL DIRECTOR <u>W. J. Lachner & Son</u> ADDRESS <u>North + Penn ave.</u> 25a. REC'D BY REGISTRAR <u>SEP 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If required, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CAROLINE</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>PRESTON RD</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>PRESTON RD</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Route 50</i>					d. STREET ADDRESS <i>R.F.D. # 1</i>					
3. NAME OF DECEASED (Type or print) <i>William Theodore</i>					4. DATE OF DEATH Month <i>Sept</i> Day <i>6th</i> Year <i>1966</i>					
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-19-02</i>		9. AGE (In years last birthday) <i>63</i> IF UNDER 1 YEAR: Months <i>05</i> Days <i>12</i> IF UNDER 24 HRS. Hours <i>00</i> Min. <i>00</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>roads board</i>			11. BIRTHPLACE (State or foreign country) <i>Trenton, New Jersey</i>			12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>					14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>Yes W W 1</i>			16. SOCIAL SECURITY NO. <i>218-12-1478</i>		17. INFORMANT Address <i># 1</i> <i>Mrs. Sarah L. Kraus, Preston, Maryland R.F.D.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>										
4201 DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> e.m. <i>19</i> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Heavy</i>		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Louis S. Welty</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>Louis S. Welty</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED <i>9-6-66</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					22b. DATE THEREOF <i>9/9/66</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Junior Order Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Near Preston, Maryland</i>	
23. FUNERAL DIRECTOR <i>J. J. Frampton and Son</i>					ADDRESS <i>Federalsburg, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 14 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND, STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Worton (Adult Lifetime)						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SEWELL Middle JEWELL Last LEE					4. DATE OF DEATH Month 9 Day 27 Year 1966						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 4 1887		9. AGE (In years last birthday) 79 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Feed Salesman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wm. Lee					14. MOTHER'S MAIDEN NAME Florence Dowling						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 161 03 4510		17. INFORMANT Address Helen E. Lee Worton, Md. wife						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Heart, Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Sigmoid Colon - 6 days post-op										INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 3-27 , 19 66 , to 9-27 , 19 66 , that (I) (we) last saw the deceased alive on 9-27 , 19 66 , and that death occurred at 5 p.m. from the causes and on the date stated above.											
22a. SIGNATURE R. Lane Wroth					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-28-66				
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth			22d. ADDRESS M.D. St. Michaels., Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/29/66		23c. NAME OF CEMETERY OR CREMATORY Chester Cem.			23d. LOCATION (City, town or county) (State) Chestertown, Md.			
24. FUNERAL DIRECTOR J. Willis Wells					ADDRESS Chester Town Md		25a. REC'D BY REGISTRAR SEP 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13264 D.O.A. 7³⁰ AM

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY QUEEN ANNES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL QUEENSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 17-2	
3. NAME OF DECEASED (Type or print) GERALD ROBERT LYON		4. DATE OF DEATH Month 9 Day 22 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1909
9. AGE (In years, last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 30 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (State or foreign country) Waldwick, Bergen Co., N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Byron Lyon		14. MOTHER'S MAIDEN NAME FLORENCE MERCER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 100-09-2238	
17. INFORMANT WIFE		Address Mrs. Mary Frances Lyon, Queenstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE PAW K. Reed M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Bob V Rieckert		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept. 24, 1966	
23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION (City or Town) Centerville, Maryland (County) _____ (State) 21617	
24. FUNERAL DIRECTOR James H. Butler Jr., Butler Bros., Centerville, Md.		25a. REG'D BY REGISTRAR SEP 26 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		22. DATE SIGNED 9-22-66	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY X CAROLINE Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X PRESTON X MD Trappe 20-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS MAIN ST P.O. Box 161	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Conroy Last Marth		4. DATE OF DEATH Month SEPT. Day 15 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store	9. AGE (In years last birthday) 59 yrs.
11. BIRTHPLACE (State or foreign country) Talbot Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME Peter Marth		14. MOTHER'S MAIDEN NAME Katherine Conroy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-4116	
17. INFORMANT Mrs. Medora Marth		Address Trappe Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion of prior Coronary 4201 DUE TO insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 3 40 p.m. 8-15- 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis D. Welty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Welty		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		for DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 19, 1966	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park Rt 50 Chantoy Talbot Md	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR SEP 19 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13278						13272					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Talbot			a. STATE			b. COUNTY		
			MARYLAND			Maryland			Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Rural - St. Michaels			3 wks			Easton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Rio Vista Nursing Home						410 North St.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			Month Day Year		
First Middle Last						September 24, 1966					
JOSEPHINE HOWETH MILES											
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		March 6, 1885		81 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Housewife				----				Crisfield, Maryland			
13. FATHER'S NAME						12. CITIZEN OF WHAT COUNTRY					
Charles W. Howeth						USA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						14. MOTHER'S MAIDEN NAME					
No						Laura Dodson					
16. SOCIAL SECURITY NO.						17. INFORMANT Address					
						MRS MARY FORD UPPER FAIRMOUNT, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary - severe</i>											
4221 DUE TO (b) <i>atherosclerotic cardiovascular</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
Very advanced senile changes.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 9-10-1966 to 9-26-1966, that (I) (we) last saw the deceased alive on 9-26-1966, and that death occurred at 9:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 9-26-66 22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) GUY M. REBSER, Jr., M. D. 22d. ADDRESS St. Michaels, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 9/27/1966 23c. NAME OF CEMETERY OR CREMATORY ST. ANDREW CEMETERY 23d. LOCATION (City, town or county) (State) PRINCESS ANNE, MD.											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LEVIN R. WILSON PRINCESS ANNE, MD. 25a. REC'D BY REGISTRAR DATE OCT 3 1966 25b. REGISTRAR'S SIGNATURE Charles Judge											

LEVIN R. WILSON PRINCESS ANNE, MD.

BURIAL 9/27/1966

ST. ANDREW CEMETERY

PRINCESS ANNE, MD.

ST. MICHAEL'S, BALTIMORE

ST. MICHAEL'S, BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #0387 9/29/66 pc

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>20 da.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		d. STREET ADDRESS <u>Memorial Hospital</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise Mitchell</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1883</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>06</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>JULIA DEMBY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-2671</u>	
17. INFORMANT <u>Hosp. Rec.</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thromboses</u> DUE TO (b) <u>atherosclerosis cerebrovasc</u> DUE TO (c) <u>advanced senile changes</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> , 19 <u>52</u> to <u>9-22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-22</u> , 19 <u>66</u> , and that death occurred at <u>11:55</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>Guy M. Preeser</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Guy M. Preeser</u>		22d. ADDRESS <u>St. Michaels Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-26-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CHARLES THOMAS CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>Talbot Md</u>	
24. FUNERAL DIRECTOR <u>James B. Dashiell, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13280					13274				
1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON			c. LENGTH OF STAY IN lb 21 hrs 30 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital					d. STREET ADDRESS --				
3. NAME OF DECEASED (Type or print) Anna First Josephine Middle Moore Last					4. DATE OF DEATH 9-11-66 Month 9 Day 11 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1877		9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR Months 1 Days 26 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Charleston, South Carolina			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Stillson					14. MOTHER'S MAIDEN NAME Carroll				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Lawrence R. Moore		Address Vienna, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial infarction DUE TO (b) Coronary atherosclerosis (vascular disease) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1992									INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 10, 1966 to Sept 11, 1966 , that (I) (we) last saw the deceased alive on Sept 10, 1966 , and that death occurred at 2 p.m. M, from causes and on the date stated above.									
22a. SIGNATURE R. Lane Wroth					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-12-66		
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth					22d. ADDRESS M.D. St. Michaels, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF September 14, 1966		23c. NAME OF CEMETERY OR CREMATORY Miami City Cemetery		23d. LOCATION (City or Town) (County) (State) Miami Florida			
24. FUNERAL DIRECTOR Tramptson Funeral Home					ADDRESS Federalburg, Md.		25a. REC'D BY REGISTRAR SEP 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

1957

RECORD OF DEATH

1957

Birthplace

Married

Vienna

Wood

Josephine

Ann

July 12, 1957

Female, white

Charleston, South Carolina, USA

None

Housewife

Catonsville

Franklin

Unknown

Lawrence J. Moore

Vienna, Maryland

No

A. J. Moore, Jr., Maryland

P. J. Moore

Portsmouth, 1966, 1967, City Cemetery

Removal

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13281					13275					
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>			c. LENGTH OF STAY IN lb <i>7 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rhodesdale</i> <i>09.2</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial</i>					d. STREET ADDRESS <i>R.F.D.</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Lloyd James Murphy</i> First Middle Last					4. DATE OF DEATH <i>September 14 19 66</i> Month Day Year					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>June 12, 1896</i>		9. AGE (In years last birthday) yrs. <i>70</i>		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester County, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Daniel J. Murphy</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Thompson</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>201-05-4572</i>		17. INFORMANT Address <i>Mrs. Hazel H. Murphy, Rhodesdale, Md. R.F.D.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4201</i> IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Emphysema</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>14 Sep</i> , 19 <i>66</i> , to <i>14 Sep</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>14 Sep</i> , 19 <i>66</i> , and that death occurred at <i>11 08</i> P, from causes and on the date stated above.										
22a. SIGNATURE <i>Steph P. Carney</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>16 Sep 66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M.D.</i>					22d. ADDRESS <i>Easton, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>September 18, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brookview Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Brookview, Maryland</i>				
24. FUNERAL DIRECTOR <i>Norm Thompson Jr. - Federalburg, Maryland</i>					25a. REC'D BY REGISTRAR DATE <i>SEP 21 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

1893

CERTIFICATE OF DEATH

1893

Northampton

Northampton

Northampton

Northampton

Northampton, June 12, 1893

Northampton County, N.H.

Northampton, N.H.

Northampton, N.H.

Northampton, N.H.

Northampton, N.H.

Northampton, N.H.

Northampton, N.H.

Northampton, N.H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b One Year d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES EASTON					2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 107 Church Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Eulalia Crocheron First Middle Last 4. DATE OF DEATH September 10 19 66 Month Day Year					5. SEX F 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 26, 1891 9. AGE (in years last birthday) 75 yrs. IF UNDER 1 YEAR: Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home					11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md. 12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Eugene Crocheron					14. MOTHER'S MAIDEN NAME Trifinia Johnson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown					17. INFORMANT Mr. Hamilton North, Cambridge, Maryland Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) many years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/24/65 , 19 65 to 9/10 , 19 66 , that (I) (we) last saw the deceased alive on 9/7 , 19 66 , and that death occurred at 11:58 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Stephen O. Carr						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-12-66	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept 12 1966		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR 28 Compton F.H. Cambridge, Md.						ADDRESS		25a. REC'D BY REGISTRAR SEP 14 1966	
								25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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107 Church Street
Trenton, New Jersey

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>13283</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>13277</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>3 da.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Easton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS <u>20-1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>NEILLIE</u> Middle <u>CHATMAN</u> Last <u>PAYNE</u>						4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-10-1908</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>UNKNOWN</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-24-1286A</u>		17. INFORMANT <u>Hospital Records</u>				Address <u>Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2nd degree burns RT arm. Uremia</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Spilled grease on arm cooking 9-4-66</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>e.m.</u> <u>9-4</u> 19 <u>66</u> <u>p.m.</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Easton Talbot Md</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>66</u> to <u>9-11</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>9-11</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert W. Trever</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James B. Washell</u>						22d. ADDRESS <u>Easton, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Talbot Md</u>			
24. FUNERAL DIRECTOR <u>James B. Washell</u>				ADDRESS <u>Easton, Md</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

78

2

VR AISME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	
3. NAME OF DECEASED (Type or print) <i>Luther N Goldsborough Phippin</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>12</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6, 1918</i>
9. AGE (In years last birthday) <i>48</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Hebron, Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Hebron, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charlie Wesley Phippin</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Parsons</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Norma Phippin, RD 1 Salisbury, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>9-12-66</i> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/15/1966</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hebron Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Hebron, Md.</i>	
23. FUNERAL DIRECTOR <i>MURRICE E. NEWMAN & SON, Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 15 1966</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #2c & d infor. taken from birth cert.									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>62 Graham St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lenny</u> Middle <u>Linda</u> Last <u>Sherwood</u>					4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/10/66</u>		9. AGE (In years last birthday) <u>6 weeks</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Jacob Sherwood</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Holland</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother Mrs. Josephine Sherwood</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized septicemia - acute</u> 3912 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>? middle ear infection?</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Louis O. Kelly</u> M.D.					22. DATE SIGNED <u>9-26-66</u>				
EXAMINER'S NAME (Type) <u>KELTY</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Talbot Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Talbot Md</u>			
24. FUNERAL DIRECTOR <u>James B. Doshell Easton Md</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Foston</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Thomas</u> Last <u>Sinclair</u>			4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1966</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/1881</u>		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine Police</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Gus Sinclair</u>					14. MOTHER'S MAIDEN NAME <u>Tabitha Walker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-1678230</u>		17. INFORMANT <u>Mrs. Wm. Roe, Tilghman, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular Encephalopathy</u> 422.1 (b) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 16, 1966</u> to <u>Sept 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 16, 1966</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>R. Lane Wroth</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-15-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth, M.D.</u>				22d. ADDRESS <u>St. Michaels</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/16/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sherwood, Md.</u>			
24. FUNERAL DIRECTOR <u>M. E. Newman & Son</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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INSTITUTE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> <div> <div>13287</div> <div>Item #20 & d Film #0351 9/28/66 pc</div> </div> <div> <div>13281</div> <div></div> </div> </div> <div style="text-align: center;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>											
1. PLACE OF DEATH a. COUNTY Talbot				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Talbot							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL EASTON				c. LENGTH OF STAY IN 1b 20-1				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL Bellevue EASTON			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL Hospital				d. STREET ADDRESS Box 531				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUISE				First E Middle S Last SMITH				4. DATE OF DEATH Month 9 Day 7 Year 1966			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 21, 1913		9. AGE (in years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY SEA FOOD		11. BIRTHPLACE (County & State, or foreign country) Talbot, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CLARENCE GIBSON						14. MOTHER'S MAIDEN NAME CARRIE PHILLIPS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 160-34-0693		17. INFORMANT WILLIAM SMITH		Address BELLE VUE, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic Myelogenous (b) Leukemia (c) Myelogenous										INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-2 , 19 66 to 9-7 , 19 66 , that (I) (we) last saw the deceased alive on 9-7 , 19 66 , and that death occurred at 4:35 P. M., from the causes and on the date stated above.											
22a. SIGNATURE William Smith				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 9-11-66			
22c. PHYSICIAN'S NAME (Type) James B. Nash				22d. ADDRESS Easton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-10-66		23c. NAME OF CEMETERY OR CREMATORY RICHARDS CEMETERY		23d. LOCATION (City, town or county) (State) EASTON Talbot Md.					
24. FUNERAL DIRECTOR James B. Nash				ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR SEP 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13288

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN lb <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u>				d. STREET ADDRESS <u>et. 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Pritchett</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>17</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1888</u>	9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>17</u> Min.	11. BIRTHPLACE (County & State, or foreign country) <u>CAROLINE MD.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HABDOKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PHILIP PRITCHETT</u>	
14. MOTHER'S MAIDEN NAME <u>MIRAR PRITCHETT</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>210-07-7372</u>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> 157X DUE TO <u>metastatic to liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic to liver</u> (c) <u>metastatic to liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>2 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u>				22b. DATE SIGNED <u>9/17/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>	
22d. ADDRESS <u>Easton, Maryland</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SAND TOWN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>Caroline Md.</u>	
24. FUNERAL DIRECTOR <u>James H. Dashiell, Easton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
13288													
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>18 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARMONY (PRESTON RFD)</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maurice Linwood Todd</u>			4. DATE OF DEATH Month Day Year <u>9-10-1966</u>			5. SEX <u>MALE</u>			6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Nov. 14, 1906</u>			9. AGE (In years last birthday) <u>59</u> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck owner & manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pickle works</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Caroline County, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Frank Linwood Todd</u>						14. MOTHER'S MAIDEN NAME <u>Ella M. Gossage</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. —			17. INFORMANT <u>Mrs Maude M. Todd</u>			Address <u>Preston, Md. RFD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>acute myocardial infarction</u> DUE TO (c) <u>1 hr.</u> <u>1 1/2 hr.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 1/2 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>10 Sept, 1966</u> to <u>10 Sept, 1966</u> , that (I) (we) last saw the deceased alive on <u>10 Sept, 1966</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Mrs. Harris</u>						22b. DATE SIGNED <u>10 Sept 66</u>			22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISIN</u>				
22d. ADDRESS <u>Carlton, Maryland</u>						22e. REC'D BY REGISTRAR <u>SEP 14 1966</u>			22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>9-12-66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Federalburg, Md.</u>				
24. FUNERAL DIRECTOR <u>from Transpore, Federalburg, Maryland</u>						25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

13284

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON MD		c. LENGTH OF STAY IN 1b 10 d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 3902 Southern Ave	
3. NAME OF DECEASED (Type or print) FANNIE E WAGNER		4. DATE OF DEATH Month 9 Day 12 Year 19 66	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-1889
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles C. Brehm	
14. MOTHER'S MAIDEN NAME Lydia Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Herman H. Wagner RFD#1 Greensboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia 4500 DUE TO (b) Fractured left hip Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis and anemia			INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY - Month, Day, Year Hour 4:35 p.m. 2 Sept 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Greensboro Caroline Md	
21. I certify that (I) (this hospital) attended the deceased from 19 66 , to 19 66 , that (I) (we) saw the deceased alive on 19 66 , and that death occurred at 4:35 M, from causes and on the date stated above.			
22a. SIGNATURE H. Kinnamon, M.D.		22b. DATE SIGNED SEP 20 1966	
22c. PHYSICIAN'S NAME (Type) H. Kinnamon, M.D.		22d. ADDRESS Easton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/19/66	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Catonsville, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 20 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

52551

CERTIFICATE OF DEATH

13291

13285

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORDOVA</u>	
c. LENGTH OF STAY IN lb <u>5 hrs 2 mins</u>		20-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u>		d. STREET ADDRESS <u>P.O. Box 79</u>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL</u> First Middle Lost <u>WARNER</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>19 66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <u>3</u> <u>2</u> min.
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Emory Stater</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Elizabeth Warner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mabel Elizabeth Warner--Mother Cordova, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776 X Prematurity</u> DUE TO (b) <u>776 X</u> DUE TO (c) <u>776 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12:20</u> , 19 <u>66</u> , to <u>12:20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Tyler Baker</u> M.D.		22b. DATE SIGNED <u>9/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Tyler Baker</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR <u>Memorial Hospital, Easton, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 5 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

INCENERATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1932

1932

3

Blank ledger page with horizontal ruling lines and vertical column lines.

Vertical text on the right margin, likely a page number or reference code.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13286

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 18 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. STREET ADDRESS 111 Reliance Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George First HANDY Middle H Last White		4. DATE OF DEATH 9 Month 26 Day 19 Year 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH February 7, 1891		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics Inc.		11. BIRTHPLACE (County & State, or foreign country) Caroline County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Newton M. White		14. MOTHER'S MAIDEN NAME Ruth Dew	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03 -9647		17. INFORMANT Mrs. Hilda P. White, Federalsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201		INTERVAL BETWEEN ONSET AND DEATH 6 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 18 Sep , 19 66 , to 26 Sep , 19 66 that (I) (we) lost saw the deceased alive on Sept 26 , 19 66 , and that death occurred at 5:30 M, from causes and on the date stated above.					
22a. SIGNATURE Stephen R. Carney		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-27-66	
22c. PHYSICIAN'S NAME (Type) Stephen R. Carney		22d. ADDRESS M.D. Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1966		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	
23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland					
24. FUNERAL DIRECTOR J. J. Drampton & Son		ADDRESS Federalsburg, Md.		25a. REC'D BY REGISTRAR SEP 30 1966	
25b. REGISTRAR'S SIGNATURE J. Charles J.					

13280

13280

CERTIFICATE OF STATE

Caroline

Maryland

Index

Federal

111 Bellvue Avenue

HANDY

February 7, 1992

White

Male

Caroline County, Md. U.S.A.

Maryland Finance Inc.

Forman

Buch Day

Newton M. White

213-CJ-9047 Mrs. Hilda L. White, Federal, Md.

NO

60741

Sept. 22, 1992

1111 Grand Convent

Federal Court, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
13287									
1. PLACE OF DEATH a. COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton					c. LENGTH OF STAY IN 1b 20 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Artemas Wilhelm					4. DATE OF DEATH 9 30 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1893		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist and Broiler Grower		10b. KIND OF BUSINESS OR INDUSTRY Broiler Grower		11. BIRTHPLACE (County & State, or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Harry E. Wilhelm					14. MOTHER'S MAIDEN NAME Ada Daniels				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-03-6383		17. INFORMANT Mrs. Anna Wilhelm, Federalsburg, Md., RFD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma DUE TO 2021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2021 (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 Sep, 1966 to 30 Sep, 1966 that (I) (we) last saw the deceased alive on 9/30 1966 and that death occurred at 9:00 PM from causes and on the date stated above.									
22a. SIGNATURE Stephen P. Carney					22b. DATE SIGNED 10-2-66			22c. PHYSICIAN'S NAME (Type) Stephen P. Carney	
22d. ADDRESS Easton, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1966		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery			23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware		
24. FUNERAL DIRECTOR J. J. Frampton & Son					25a. REC'D BY REGISTRAR OCT 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1322

OFFICE OF THE DIRECTOR

1952

Caroline

Caroline

Caroline - 1952

Caroline - 1952

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Caroline

Oct. 22, 1952

Oct. 22, 1952

USA

Washington, D.C.

Washington, D.C.

Mr. Daniel

Mr. Daniel

Mr. Daniel, Washington, D.C.

1952

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

Mr. Daniel, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13294

13288

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>5 HR.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>20-1</u>			
3. NAME OF DECEASED (Type or print) <u>Woodrow W. Wilson</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1913</u>		9. AGE (In years last birthday) <u>53</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Md.</u>			
13. FATHER'S NAME <u>John W. Wilson</u>			14. MOTHER'S MAIDEN NAME <u>Ethel James</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-07-4938</u>		17. INFORMANT <u>Mrs. John W. Wilson, Tilghman, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150x</u> <u>cochepia - severe</u> (b) <u>adenoca. Esophagus</u> (c) <u>widened intestines</u> DUE TO (b) <u>adenoca. Esophagus</u> DUE TO (c) <u>widened intestines</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>9-16-66</u> to <u>9-18-66</u> , that (I) (we) last saw the deceased alive on <u>19-18-66</u> and that death occurred at <u>3:30</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Wm. B. Reese Jr.</u>		22b. DATE SIGNED <u>9-19-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Wm. B. Reese Jr.</u>			
22d. ADDRESS <u>St. Michaels Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>9/20/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Tilghman, Md.</u>			
24. FUNERAL DIRECTOR <u>Maurice E. Neumann + Son Easton Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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2861

CERTIFICATE OF DEATH

13295

13289

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>20-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>408 S. Washington Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Kemp</u> Last <u>Wyatt</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>19</u> - Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Percy Wyatt</u>		14. MOTHER'S MAIDEN NAME <u>Katie Kemp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-05-3709</u>	
17. INFORMANT <u>Mrs. Percy K. Wyatt, Easton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Acute myocardial infarction with</u> DUE TO (c) <u>acute pulmonary edema</u> <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9-19-66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>66</u> to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>5:30</u> a.m., from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/21/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>	
24. FUNERAL DIRECTOR <u>Maureen E. Newman, Son Easton Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

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Robert L. Taylor

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